PPO HEALTH BENEFIT PLAN COMPARISON FORM

BENEFIT	PPO STANDARD PLAN (Limits Apply Regardless of Network Status)		XXX Plan	
	IN NETWORK	OUT OF NETWORK	IN NETWORK	OUTOFNETWORK
Deductible Maximum out of Pocket for Covered Expenses After Deductible Coinsurance Lifetime Maximum Benefit	Single $400 Family $800 Single $1500 Family $3000 As Indicated Deductible Applies * Unlimited	Single $700 Family $1400 Single $2500 Family $5000 As Indicated Deductible Applies* Unlimited		
In-Hospital Care - Authorized In-patient Care, Semi Private Room and Misc. Services, Intensive/Cardiac/Neonatal, Ancillary Services, Preadmission Testing	15% Coinsurance	35% Coinsurance*		
Transplant (Kidney, Cornea, Bone Marrow, Heart, Liver, Lung, Heart/Lung, Pancreas, Small Bowel	15% Coinsurance	35% Coinsurance*		
Ambulatory/Hospital Outpatient Surgery	20% Coinsurance*	40% Coinsurance*		
Out-Patient Services - Provider Office Visit, Office Diagnostic & Allergy Testing, Allergy Serum and Injections, Diabetes Education, Therapy, Radiation, Chemotherapy, and Dialysis	$10 Copayment for Office Visit 20% Coinsurance* for Other than Office Visit	40% Coinsurance*		
Diagnostic Testing	20% Coinsurance	40% Coinsurance		
Maternity Care - Prenatal, Labor, Delivery and Postpartum	$10 Copayment for Office Visit for Diagnosis	35% Coinsurance* Dependents Covered		
Emergency Services - Hospital Emergency Room (Coinsurance Waived if Admitted)	20% Coinsurance*	20% Coinsurance*		
Ambulance – Ground Only	20% Coinsurance	20% Coinsurance		
Preventive Services: Immunizations Well Child Care - Age and Periodicity Limits May Apply Well Adult Care - Age and Periodicity Limits May Apply	10% Coinsurance Per Plan Year Ages 0-3 Office Visits Covered to $200 - Ages 4-18 Office Visits Covered to $100 - No Coverage Above Limit - $10 Copayment Per Plan Year $300 for Routine Physical Exam and Specified Testing No Cover-age Above Limit - $10 Copayment	Preventive Services Are Not Covered Out of Network		
Mental Health Inpatient (Day Treatment/Intensive Outpatient Can Be Substitute for Inpatient Days on a 2:1 Basis) Outpatient Autism (Ages 2 through 21) $500 Monthly Benefit (Therapeutic, Respite, and Rehabilitative Care)	20% Coinsurance, 21 days/plan year, 1 admission/6 months* 20% Coinsurance, 20 visits/ Plan Year* Copayment or Coin-surance* Applicable to Service Provided	40% Coinsurance 21 days/Plan Year, 1 admission/6 month 40% Coinsurance, 20 visits/ Plan Year* Coinsurance Applicable to Service Provided*		
Substance Abuse Same Coverage and Limits as Mental Health	Same Benefit Level as Mental Health	Same Benefit Level as Mental Health		
Prescription Drugs and Contraceptives	20% Coinsurance - 1 month supply*	40% Coinsurance- 1 month supply*		

Benefit Reductions Or Denials Can Result From Failure To Follow The Plan's Rules
Ask What Restrictions Apply!
Benefits and Exclusions Are Subject To Modification Upon Renewal

(2002 Edition)

PPO HEALTH BENEFIT PLAN COMPARISON FORM

BENEFIT	PPO STANDARD PLAN (Limits Apply Regardless of Network Status)		XXX Plan	
Physical/Occupational/Cardiac Rehabilitation Therapy	20% Coinsurance 26Weeks/PlanYear *	40% Coinsurance 26 Weeks/Plan ear*		
Speech Therapy	20% Coinsurance 26Weeks/PlanYear *	40% Coinsurance 26 Weeks/PlanYear*		
Home Health Care	100 Visits Per Plan Year Covered in Full	20% Coinsurance* - 100 Visits Per Plan Year		
Skilled Nursing Facility	20% Coinsurance 28 Days/Plan Year *	40% Coinsurance 28 Days/Plan Year*		
DME/Prosthetics/Hearing Aids	20% Coinsurance*	40% Coinsurance*		
Hospice	Medicare Benefit*	20% Coinsurance Medicare Benefit*		
Additional Rows as needed for Supplemental Benefit Riders				
MONTHLY PREMIUM	$		$	

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